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Back to the Future in NHS Reform

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This paper is circulated for discussion purposes only and its contents should be considered preliminary.

Abstract

Purpose - In the mid 1990s the NHS 'did' competition, in the mid 2000s the NHS is 'doing' choice. This paper aims to cut through the rhetoric, highlight the differences and parallels between then and now and identify if these differences will have a different or the same impact on local services.

Design/methodology/approach – Following a review of literature from the 1990s, a qualitative research study is used to examine the impact of competition and markets in the 1990s. The discussion examines the implications of this study for current system reform.

Findings - Patient choice recreates many of the features of the internal market, but despite concerns at the time, the internal market did not have a significant impact on services. It is likely that patient choice will similarly have a limited impact.

Research limitations/implications - The research is a case study confined to Day Surgery in one part of the North of England.

Originality/value - The paper reminds academics and practitioners what happened last time the NHS attempted to introduce a market-based system.

Key words - National Health Service, Choice, competition, markets

Paper type - General review

Back to the Future in NHS Reform

Introduction

In 1990 the NHS and Community Care Act introduced an ‘internal market’ for health care, with the aim of improving patient services and making the NHS more efficient and responsive to patient needs. However, in the run-up to the 1997 general election, the system was heavily criticised by the opposition parties and media. Specifically, it was said to have led to a two-tier system, where some patients of General Practice Fund Holders (GPFHs) could access care more speedily than those patients on the list of non-fund holding practices. After its election, although the incoming Labour Government retained some elements of the internal market including the purchaser provider split, they wasted no time in abolishing GPFHs (Klein 2001, Mannion 2005).

The same Government, now in its third term of office is introducing the Patient Choice initiative, which allows General Practitioners (GPs) and their patients to choose which hospital to attend, (DoH 2005). If patients are to be given a choice of health care provider, they have to be offered a range of providers and some form of quasi market structure has to be assembled.

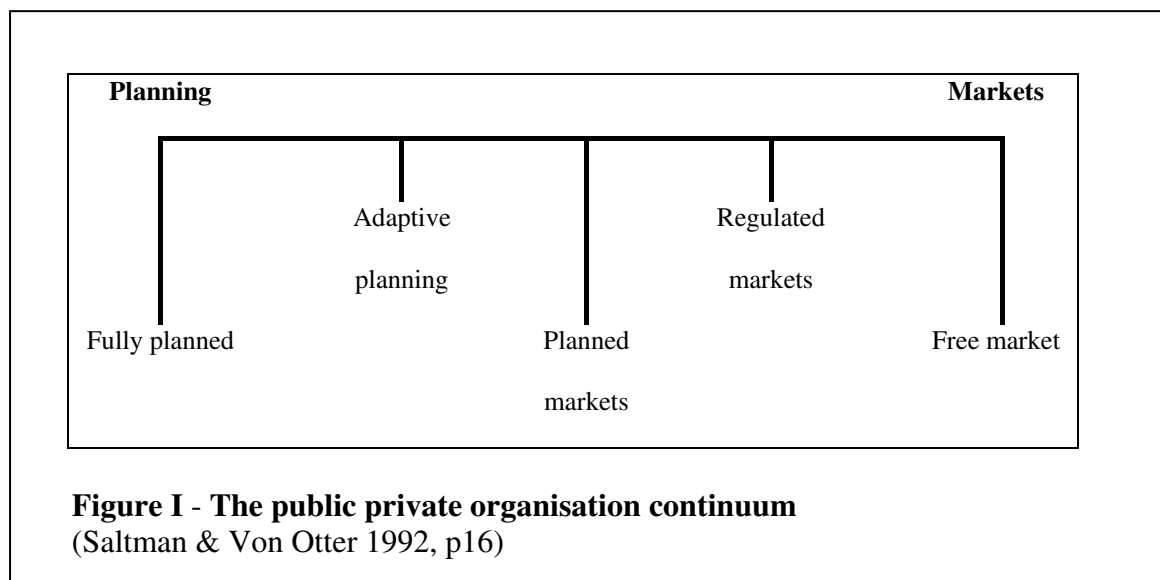
This paper investigates whether the Patient Choice initiative could inadvertently turn the clock back 10 years to the mid 1990s and whether the Government learnt from the fund-holding episode, or will the same challenges be faced? In this context, it focuses on the issue of whether the ‘incentivised NHS’ (p68) and ‘contestability’ (p72) of the noughties, (DoH 2004a) are so different to the ‘competition’ of the early 1990s, (DoH 1989) and whether practice based commissioning be so different to GPFH?

The paper offers a review of what happened in one locality in the mid 1990s and explores the potential for the NHS to rediscover some of the problems relating to the inequities of the ‘two tier’ system. It will seek to illuminate differences between the policy rhetoric and policy in action, in the 1990s and now. The paper argues that the unspoken downside of giving patients choice and rewarding performance is that competition between providers can lead to winners and losers in the quest for funds and that by focussing the message on giving patients a choice, the Government is down playing the possible impact of reintroducing an internal market for health care.

The final section of the paper offers comments on what might happen next. The research case study in the mid 1990s found that the internal market did not have a significant impact on local services. The paper argues that introducing choice may also ultimately prove to have a limited impact on service provision

The Internal Market in the mid 1990s

Towards the end of the 1980's, European Governments were keen not to commit more and more resources to what was believed to be expensive, inefficient health care systems (Saltman and Van Otter 1992, p12). Instead, they looked for ways in which the systems could become more productive, make better use of resources and be more responsive to patient needs. The emergence of planned markets at the time in the UK mirrored a shift in most European nations along a policy continuum from fully planned to a free market system (see figure I). Saltman and Van Otter described the 1980s NHS as a classic example of a planned, centrally budgeted system that, in the mid 1990s, was moving towards the middle ground represented by "planned markets", (p16). It could be argued that the Blair Government is now proposing a further move along the continuum towards regulated markets, (Pollock 2005).



Calls for the introduction of a market were made in a Ministerial Review of the NHS in 1988. Several years earlier Alain Enthoven of Stanford University, had already suggested the need to focus on incentives for efficiency and innovation in the

provision of UK health care. He advised the then Government to drop the link between spending and provision (purchasing and providing) by creating an internal market (Enthoven 1985). Tilley (1993) suggests that the Conservative Government aligned themselves with these ideas because it matched its supply side economic views, and because it saw Enthoven's ideas as a means of eliminating further monopoly provision in the public sector.

At the time, researchers and commentators predicted that the reforms would have little impact outside London or the other main urban areas (Paton 1992, Nettle 1993, Baeza et al 1993). Lessons from the United States suggested that competition would indeed be possible in a range of urban and rural environments (Morrissey et al 1988), but in reality the Government could not afford competition to de-stabilise hospital services, (Pollock 2005), so competition never had the impact some commentators had anticipated.

The main criticisms levelled at the purchaser/provider split and fund holding in the 1997 election campaign was the suggestion that it had created a two-tier system for health in certain locations. This was thought to be due to two reasons. First, that more money per patient was available to fund holder GPs than to the District Health Authorities (DHAs), who contracted with hospitals for services for patients listed with non fundholding GPs. Secondly, it was argued that GPFHs made service planning difficult as their priorities were at odds with the DHA, (Tilley 1993, p3). For example, by shifting services between the Trust Hospitals, GPFHs could destabilise the allocation of funds, which could lead to some service closures.

GPFHs were also criticised for using NHS funds in the independent sector, (private for profit and non-profit making organisations) and for retaining surpluses that could have been spent on improving health care (Dusheiko et al 2004). At the time, the Conservative Government and some commentators suggested that financial incentives and the independent sector had the potential for a larger role in reforming the NHS. (Glennerster et al 1993). Some of these arguments have recently resurfaced with some arguing in favour of using more private sector provision as a way of expanding capacity and capability and critics raising similar doubts to those raised in the 1990s about the negative consequences of financial incentives and the greater involvement of private sector providers.

Methodology

This paper is based in part, on research, which was undertaken in 1994 and 1995. The focus of this research was to determine what impact of competition and marketing techniques had on the provision of day surgery three and a half years into the purchaser provider split. The study focussed on one relatively self contained area, South Durham and Teesside ^[1] (Warwick 1995).

The original research centred around three hypotheses, which had been developed following a comprehensive literature search, (see figure II). Questions related to these research hypotheses were raised with key players in a series of 14 semi-structured interviews. The interviewees included Contract Managers in provider hospitals, (NHS Trusts and Independent Sector), Locality and Commissioning Managers in DHAs, Managers in Fund-holding practices and a Community Health Council Chief Officer, (a patient advocate organisation which were in existence between 1974 and 2002). In line with standard qualitative methodology, it was expected that the interviews would allow for a factual evaluation of the key hypotheses while the more open-ended questions would facilitate the development of understanding and perspective, on the subject matter, (Easterby-Smith et al 1991).

Figure II. Research hypotheses, 1994

- The professional focus of the health service remains pre eminent despite three years of the reforms, (which aimed to create a more patient-centred approach), and three years of a managed market.
- The traditional pattern and location of service delivery in South Durham and Cleveland remains largely unchanged, and
- Marketing techniques have had little if any impact on the customers or service users

Geography determined which GP Practice Managers were approached. All those willing to take part were interviewed. The same applied to the two DHAs which covered the study area. Managers at two of the four Trusts agreed to be interviewed. Several Community Health Concils could have been involved, but in the end the only

¹ The choice of study area seemed to be appropriate because there were a reasonable number of acute hospital services Trusts (six) two Health Authority purchasers, and twenty GPFHs, in a mixed rural and urban area. This type of area had not been studied in any similar research at the time.

one was available to be interviewed. Following selection each potential interviewee was sent a letter of introduction at the end of June 1994, which stated the research intention and informed them that they would be contacted two weeks hence. On the whole the interview provided relevant information, albeit that minor difficulties were encountered later on during the study. The problems arose from three sources. Firstly, interviewees tended to view the interviewer, as a representative of a Trust, rather than as an independent researcher. This appeared to encourage some interviewees to play down issues specific to that Trust, although this was taken into account in interpreting the results there is no guarantee that if interviewees wished to be creative, they could negatively affect data integrity ^[2]. Secondly and related to the above, some of the providers found it difficult to share their experiences with a potential ‘competitor’ and therefore did not agree to be interviewed. Finally, there was some fatigue among interviewees who had earlier been confronted with several research and marketing exercises. This was particularly apparent in the case of some GPFH Practice Managers, who expressed frustration that they were continually being requested to participate in research, or were being courted by providers from all over the North East.

The next stage of the research involved a wider questionnaire survey, which was intended to triangulate the views of the 14 interviewees, whose views largely supported the three hypotheses initially developed. The questionnaire was aimed at investigating the main issues on the basis of a wider sample of purchasers and providers in the study area.

One key concern in designing the questionnaire was the high response rate. With a relatively small number of people to be surveyed, a low response rate would have given very little data to work with. A further concern was to avoid research fatigue and to reduce the amount of time needed to complete the questionnaire to a minimum. As a consequence, the questionnaire was designed to fit on a single sheet. In order to introduce the subject and to provoke a response, the covering letter to the questionnaire identified the conclusions drawn from the structured interviews and asked respondents to register their own experiences.

² For example, the author discovered when interviewing one private sector hospital Business Manager, that several of the GPFH had exaggerated the number of patients they were sending to the local private sector provider.

A four-point scale was developed to encourage respondents to rank the strength of their views. Once piloted, 32 questionnaires were sent to all the NHS day surgery providers in County Durham, to representatives of the DHAs and all the GP Fund Holders in South Durham and Teesside. Moreover, several more distant practice managers who were known to refer a few patients into Teesside were also sent questionnaires.

The desired outcome of a high response rate was achieved (85 per cent). All groups returned equally well. The responses allowed more robust conclusions to be drawn about the dynamics of the market in the area.

Unfortunately, as with the interviews, there were indications that the impact of some GPFH or provider initiatives might have been exaggerated and others played down. Balancing this to a certain extent, the use of an independent University address for the questionnaire may have reduced some temptations to say what should be happening rather than what was actually happening. Yet some concerns over this issue remained. For example, it is likely that purchasers wanted to be seen to say that they were working with providers on service development, but none of the providers indicated that they were working with purchasers on such issues.

The questionnaires were analysed by categorising them in three groups: Purchasers, GPFHs and Providers using a simple scoring technique. The results of the questionnaire were put along side those from the initial set of interviews and a more detailed network of cross-references was developed. On the whole, the conclusions drawn from the interviews seemed to be backed up by the questionnaire responses.

The interviews, although time consuming, provided a detailed exploration of the key issues specific to the three main parties (DHAs, GPFH and Trusts). They also led to an understanding of the views of two other significant influences, the Community Health Council and the Independent hospital. Particularly useful was the opportunity to talk in depth to representatives on either side of the purchaser/provider divide and to assess how they perceived the outcome of negotiations and marketing initiatives.

In hindsight, it is possible to identify problems with the approach taken. In particular, the multi-dimensional, multi-factor nature of the situation to be analysed suggest that grounded theory may have been a better approach than the hybrid method adopted. The competitive and confrontational dynamics of the mid 1990s market, meant that some of the responses may have been overplayed or made for effect and

may have impacted on the validity of the conclusions. Also, the questionnaire could be criticised for being too focused and not offering enough opportunities to comment, however it did achieve the aim of a good response.

Results

The conclusions from the interviews stage of the research were:

- a) The provision of day surgery in the study area was not significantly altered by the introduction of a managed market for healthcare. The traditional pattern of service delivery in South Durham and Teesside remained largely unchanged. Those changes that had taken place were only partially attributable to the internal market.
- b) Marketing techniques had little, if any, impact on the customers (purchasers of day case surgery) or service users, (patients). Whilst marketing strategies were developed by NHS Trusts and the independent providers, they were based mainly on winning new business from neighbouring areas, rather than relationship marketing techniques.

The questionnaire responses reinforced the initial conclusions, drawn-up at the end of the interviews. There was little to contradict the view that the reforms had not influenced significant changes in the provision of services. However, all the purchasers had made changes to their day surgery services, suggesting that factors other than competition and market forces were driving service changes.

It appeared that the medical model of service provision was still the norm and that the provider/professionally driven changes were still far more significant than customer or market driven changes. Neither GPFH nor purchasers significantly rated their chances to change the shape of services. However, Trust providers were still exerting an influence over the purchasers and GPFHs but not as a result of marketing activities. Instead their influence seemed to have more to do with professional or informal contacts. In 1994 and 1995, the providers thus appeared to be still driving the system. GPFHs aimed to offer more patient choices and to improve the services available to their patients, however, when it came to influencing providers, they only appeared to have a marginal impact.

The research led to the conclusion that the provision of NHS services, including day surgery, was still led by providers and appeared to be motivated by an ‘in-built’ professional focus. Purchasers had not yet challenged this position and where changes in day surgery had taken place, this was largely as a result of provider initiatives.

There was some evidence of GPFH led innovations. Although these were emphasised by the GPFH, the numbers of patients involved were small. Some GPFHs had used their bargaining power, which was significant in parts of the study area to offer a greater variety of services to their patients, including some use of non-NHS providers^[3]. These GPFH services were not available to patients of non-fund holding GPs. The Fund holders themselves felt they had the potential to become an increasingly important change agent with the ability to challenge the pattern of the provider led NHS (Le Grand et al 1998). Obviously, since within two years of the study, GPFH arrangements were scrapped, their potential was never realised.

The research did find several examples of health care organisations using marketing techniques. For example, an independent hospital had appointed a Business Manager who was specifically courting Fund holders with a campaign of visits and marketing literature. Some of the Acute Trusts had set up an account manager system for the large GPFHs in their patch, however the approach adopted by all providers was best described as transactional marketing, aimed at promoting sales in new markets, rather than a longer term relationship marketing approach, (Kotler et al 2005), which might have led to a greater degree of inter-dependency between Trusts and GPFH, rather than adversarial approach that seemed to be the norm in the mid 1990s.

Discussion

Despite the fact that the primary research for this paper was conducted some time ago, recent developments warrant both a re-examination and re-interpretation of the findings. In 1997, The Government’s circular, ‘*The New NHS, Modern Dependable*’ (DoH 1997) refocused the efforts of NHS managers, abolishing many of the internal

³ An independent hospital with Day Surgery facilities had been used by many of the GPFHs in the study area in the early 1990s for some Day Surgery procedures in specialties with long waiting lists at local hospitals.

market arrangements. More recent years, however have seen a renewed advocacy of internal markets. Thus the Choice Initiative (DoH 2003a) and Payment by Results (PBR) arrangements (DoH 2003b, DoH 2004b), suggest that service improvements should be driven by stimulating choice for users and by implication, competition between providers. Today, NHS Managers in Primary Care Trusts (PCTs) - rather than in GPFHs - are shifting patterns of patient referrals with the aim of offering patients shorter waits and improved quality of services, (BMJ 19/11/05). For example in 2005, patients from Leeds PCTs were being treated in nearby Harrogate to avoid long waits at St James's Hospital, Leeds. Patients waiting for MRI scans in Durham were being sent to Middlesbrough (30 miles away), to have private sector provided scans.

This raises the question as to whether new initiatives aimed at creating contestability and an incentivised NHS, (DoH 2004a) are turning the clock back full circle? More importantly, it raises the issue as to whether we are about to rediscover all the problems first encountered by the internal market ten years ago and whether in this case the organisations has lost its memory, (DoH 2000a).

In the Mid 1990s the author investigated whether the policy announcements of the time, (about service improvements and customer responsiveness being driven by competition and the internal market), were being borne out in reality and whether the market and marketing techniques were improving customer (service user) responsiveness. The investigation largely suggested that this was not the case and that patient choice had in fact remained limited. This raises the question as to whether current initiatives are sufficiently different to induce more significant changes.

The Choice Initiative

The choice initiative envisions that by the end of 2005, all NHS patients will be offered a choice of 4 or 5 providers at the point of referral. In this way, patients are expected to be involved in making decisions about their treatment (<http://www.chooseandbook.nhs.uk/>). This amount of choice extends well beyond what was planned in The NHS Plan (DoH 2000b), which talked about choice of date and time but not location. Alan Milburn's '*Redefining the NHS*' speech in January 2002, expanded the concept of choice to include increasing capacity and then using funding and rewards for performance to encourage service improvements (Milburn 2002, p5). The unintended consequence of patient choice and performance reward,

needless to say, is that competition between providers can lead to winners and losers in the competition for funds.

'The NHS Improvement Plan' (DoH 2004a) and *'Creating a Patient-Led NHS'* (DoH 2005) does not make any explicit references to competition, although, *'Building for the best'*, talks about "hospitals raising their game" (DoH 2003c p2) and the PBR documentation (DoH 2003d and 2004b and 2004c), discusses in some detail the financial safeguards that will prevent hospitals losing funding from having to reduce capacity. *'Creating a Patient Led NHS'* euphemistically talks about "less certainty", "local services needing to flex", and allowing service "to exit", (DoH 2005, p33-4). The certainty afforded to some independent sector providers, with guaranteed levels of activity and support to reduce the negative consequences for some suppliers of moving onto the national tariff for treatment costs, is likely to rub salt into the wounds of some Trust managers.

For the successful organisational players in the new market, *'The NHS Improvement Plan'* (DoH 2004a) offers the "freedom to retain surpluses" (p75). One of the incentives for becoming a Foundation Trust, and *'Creating a Patient led NHS'* (DoH 2005) is payment by results which is seen as a clear incentive for an organisation to achieve desired outcomes, (DoH 2005 p32). Whether this is workable is unclear. Smith, (in Dixon et al 2003), for instance, makes the point that in common with his criticisms of the 1990s system, consultant medical staff have not been given clear incentives to respond to market forces and so they are unlikely to willingly change their patterns of work.

Incentives for organisations to treat successfully a greater number of patients and new arrangements designed to minimise the negative impact of competition on the failing organisations are an implicit acceptance that patient choice will reintroduce competition between health care providers. Despite this, the Government is still keen to focus on the differences rather than similarities to the previous system it dismantled in 1997. Le Grand, (Guardian Unlimited 2005, Dixon et al 2003), a governmental advisor on the reforms, points out that competition will not be based on price but on quality with quality being regulated by standards and inspection. In 2002, Alan Milburn then Secretary of State for Health, referred to previous health policies as "an outdated Thatcherite obsession" aimed at reducing state control, (Milburn 2002). In line with these views the current rhetoric of the Choice Initiative accentuates the consumerist agenda, rather than the creation of a marketplace.

In 1989, the Conservative Government introduced the internal market arrangements in a circular entitled *Working for patients*, (HMSO 1989). That contained references to patients choosing where to be treated, public and private sector working together, incentives for good performance and the manager of GP practices using their commissioning budgets to bring about change. All of which arrangements are arguably recreated in The Choice Initiative. Government Ministers and their advisers are unlikely to draw parallels with previous policies. It could be argued that by developing an alternative vocabulary, they have been able to avoid some uncomfortable questions about links to past much criticised initiatives from the Thatcher era. This is not dissimilar to New Labour announcing its intention to investing in NHS leadership in the NHS Plan, after criticising NHS management costs for the previous decade, (Poole 2000, Learmonth 2005). As ever, language is important in shaping policy and perceptions, even if the mechanisms are very similar.

If the Choice Initiative introduces a form of market, will the NHS organisations rediscover the need to invest in marketing initiatives and campaigns to promote their services in the newly recreated competitive environment?

Marketing

The impact of the choice initiative is yet to be fully understood. However, at this early stage, it seems unlikely that patients will choose to travel long distances to go to the healthcare providers with the best reputation and the best results. Patient choices are likely to be based on what is close by and what their GPs and other health professionals recommend, (Health Service Journal, 26/08/04b). It is possible that Healthcare Commission star ratings, (<http://www.healthcarecommission.org.uk>), media coverage, other information sources such as Dr Foster, (<http://www.drfooster.co.uk/>), MRSA infection rates and even mortality figures will play a part (Sunday Times 04/12/05), but in many parts of the country, providers are too far apart to offer desirable alternatives, (BBC News 13/07/05)

Trust Managers may wish to consider marketing techniques to promote the image of their Trusts and to court GPs and patients to exercise choices in their favour. This may or may not be as explicit as the marketing campaigns conducted by expansionist Trusts in the 1990's but marketing activity is likely to be targeted on communicating with GPs, just as it was back then, (Health Service Journal 06/10/05). Providers still face a complicated array of customers and stake holders and have

difficulty in defining their customers. They also have difficulties getting into meaningful dialogues with patients and patient groups. If these difficulties are coupled with the continuing reorganisation of PCT structures, and the limited effect of Patient Forums, the likely result is that the actual impact of patient choice and voice on the health care system is likely to remain limited, for some time to come.

Conclusions

The 1990 reforms were based on an attempt to create a system in which competition would lead to increased efficiency and improved service quality. The idea was that the market would in effect drive out inefficient provision. The Choice Initiative in the mid 2000s is arguably based on a different set of principles, with the starting point of increasing public involvement by offering choice to service users. However, both systems require a form of quasi market in which money follows activity and in which there is competition or at least *contestability*, (as it is now termed), between providers for referrals and so funding.

There are some differences between then and now. PBR and the Choice Initiative have been piloted in certain specialities and in some PCTs and Foundation Trusts, (Audit Commission 2005). The intention is for purchasers to focus on quality not cost and it appears that the new market is going to be even more of a managed market than last time.

Some lessons however have not been heeded. Despite the discussion in the circulars about pooling expertise and systems, the Audit Commission report on the PBR pilot sites raises grave concerns about data quality, IT systems and the time and resources tied up in managing the system, (Audit Commission 2005). Other commentators are concerned that yet again the focus is likely to be on the acute sector at the expense of systems to promote the community health services, (Dixon et al 2003, Mannion 2005).

The author's earlier research in 1994 and 1995 in South Durham and Teesside indicated that changes in service provision took place, in spite, rather than because, of the internal market. The contracting arrangements themselves, militated against some changes, for example, day surgery was usually part of a specialty contract, so some

GPFHs could not extricate their day case referrals from specialty contracts even if they wanted to.

Some initiatives were sparked by the GPFHs, but these were very marginal in terms of the total volume of work and took several years to take effect. Although GPFH had the potential to lead to greater and longer lasting changes, this potential was never realised because within a couple of years they were abolished. Given the track record of recent Governments, it is quite likely that, whatever happens as a result of the choice initiative, there is a possibility that it will be replaced by a new policy promising a new set of outcomes. The short to medium term impact on local services may therefore ultimately prove itself to be limited. Given the existing reform fatigue within the NHS, there is a strong possibility that staff in the NHS will carry on doing their jobs as normal (Harding 2005 and Learmonth & Harding 2003), while only senior management staff in Foundation Trusts and PCTs and a perhaps a few people in finance and information roles will be seriously affected by the Government's new agenda.

Politically, there are differences and similarities between then and now. In the 1990s, the aim was to make the service more efficient reducing the burden of the NHS on the taxpayers. The current Government agenda perhaps has a more direct appeal to the public (Le Grand 2003). Therefore perhaps patient experiences and public opinion is the most appropriate way to measure the success of the Choice initiative.

In the shorter term, research to measure the impact of choice on health care provision will be needed. A study of the same locality as that undertaken in 1994 and 1995 could provide some interesting comparative data and may allow some judgements to be made about the impact of the two sets of reforms.

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